3207-0317-3208



# PRIOR AUTHORIZATION REQUEST*

GHP
PO BOX 7000
McRAE, GEORGIA 31055

FOR DMA USE ONLY

*Include This Number On All Claim Forms*

PRIOR AUTHORIZATION NO. XXXXXX

| 1. Member Name (Last, First, Init.) | | | 2. Medicaid ID No. |
|---|---|---|---|
| 3. Birthdate | 4. Sex | 5. Address | Nursing Home ☐ Yes ☐ No / 6. Telephone (Area Code/Number) |

| 7. Prescribing Physician/Practitioner Name And Address | | 10. Provider Of Service(s) Name And Address | |
|---|---|---|---|
| 8. Medicaid Provider Number | 9. Telephone (Area Code/Number) | 11. Medicaid Provider Number | 12. Telephone (Area Code/Number) |

☐HOME HEALTH ☐PODIATRIST ☐OPTOMETRIST ☐PHYSICIAN ☐PSYCHOLOGIST ☐DME/OP ☐DDS ☐PHARMACY

| 13. Authorization Period From ___ Through ___ | 14. Description Of Service(s) Requested | DEPT. USE ONLY 15. Rec Type | 16. Ctgy. Of Svc. |
|---|---|---|---|
| | | | |

| 17. Primary Diagnosis Requiring Service(s) | 18. ICD-9-CM |
|---|---|
| 19. Justification And Circumstances For Required Service(s) (Use separate page if necessary) | |

## STATEMENT OF SERVICE(S)

| LINE NO. 20 | 21. Description Of Procedures, Drugs, Equipment, Or Other Services | 22. Procedure/ Drug Code | 23. Requested Or Estimated Price Per Unit | 24. Bill Units | 25. Months or Units Of Service | 26. Units Per Claim Max. | 26. Units Per Claim Min. | 27. Max. Units Per Month |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |

28. PROVIDER'S SIGNATURE

29. DATE SUBMITTED

| 30. REQUEST ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED | 31. DMA SIGNATURE | 32. DATE APPROVED |
|---|---|---|
| 33. Explanation to Provider | | |

**Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.*

DMA-80 (3/30) COPIES: WHITE: DAM; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER